General

Guideline Title

Depression in the long term care setting.

Bibliographic Source(s)

American Medical Directors Association (AMDA). Depression in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2011. 39 p. [91 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Depression. Columbia (MD): American Medical Directors Association (AMDA); 2003. 36 p.

Recommendations

Major Recommendations

Note from the American Medical Directors Association (AMDA) and the National Guideline Clearinghouse (NGC): The original full-text guideline provides an algorithm on "Depression" to be used in conjunction with the written text. Refer to the "Guideline Availability" field for information on obtaining the algorithm, as well as the full text of the guideline, which provides additional details.

Recognition

Step 1

Does the patient have a history of depression or a positive result on a screening test for depression?

Available transfer information, including summaries and other referral data, as well as a patient and family history, can help to identify individuals who have a history of depression, other psychiatric disorder(s), psychiatric treatment or hospitalizations, or suicide attempts. Document in the admission medical record the presence of any of these conditions or events in the patient's history. Note, however, that genetic factors are less important in late-life depression.

Appropriate screening tools include:

- 10-Item Geriatric Depression Scale (GDS) (see Appendix 1 in the original guideline)
- Cornell Scale for Depression in Dementia (CSDD) (see Appendix 2 in the original guideline)
- Patient Health Questionnaire 9 (PHQ-9; see Appendix 3 in the original guideline)

- Staff Assessment of Resident Mood (PHQ-9-OV; see Appendix 4 in the original guideline)

Step 2

Does the patient have signs or symptoms of depression?

If the patient has a history of depression, other psychiatric disorder(s), or a screening test result that indicates possible depression, members of the interdisciplinary team and direct care staff should observe him or her for current signs and symptoms of depression (see Tables 1 and 2 in the original guideline).

Step 3

Does the patient have any risk factors for depression?

If the patient does not have current signs or symptoms of depression, evaluate him or her for risk factors (see table below) and document the findings in the patient's medical record. If the patient has risk factors, develop an interdisciplinary care plan that takes those risk factors into account and maintain a high index of suspicion for depression. If no risk factors are found, continue to monitor the patient periodically for the development of risk factors as well as for signs or symptoms of depression.

Table: Some Risk Factors for Depression

- Alcohol or substance abuse
- Current use of a medication associated with a high risk of depression (see Table 5 in the original guideline)
- Hearing or vision impairment severe enough to affect function
- History of attempted suicide
- History of psychiatric hospitalization
- Medical diagnosis or diagnoses associated with a high risk of depression (see Table 6 in the original guideline)
- New admission or change in environment
- New stressful losses, including loss of autonomy, loss of privacy, loss of functional status, loss of body part, or loss of family member or friend
- Personal or family history of depression or mood disorder

Assessment

Step 4

Is it appropriate to perform a medical workup for factors possibly contributing to signs and symptoms of possible depression?

Although it is important to determine whether coexisting medical conditions or current medications may be contributing to the patient's depressive symptoms, the nature and extent of an appropriate medical workup will depend on the patient's condition, prognosis, and advance care directives, as well as on the expressed preferences of the patient or family.

For most patients in the long-term care (LTC) setting, a pertinent history and physical examination by the practitioner, the laboratory studies listed in Table 4 in the original guideline, and the standard interdisciplinary Resident Assessment Instrument process may yield findings that help with decision making.

Step 5

Is the patient taking medications that might cause or contribute to depression?

(See Table 5 in the original guideline for list of medications that may cause symptoms of depression.)

If the interdisciplinary team feels that a particular drug may be a factor in the patient's depression (e.g., there is a temporal relationship between the initiation of the drug and the onset or worsening of depressive symptoms), the practitioner may decide to discontinue or to change the medication.

The practitioner should then document the reasons for the suspicion that this medication is causing or contributing to the patient's depression. It is equally important to document the reasons for continuing the drug if the practitioner judges that it is not contributing to the patient's depressive symptoms or considers the drug essential to treatment of the condition for which it was originally prescribed.

Step 6

Does the patient have one or more conditions that may either increase the likelihood of depression or cause depressive symptoms?

Many medical and psychiatric diseases and conditions produce depressive symptoms or carry an independent risk for causing depression. These conditions need to be taken into account when a patient is assessed for depression (see Table 6 in the original guideline). A medical evaluation is important to determine the extent to which underlying medical problems cause or contribute to depressive symptoms.

Step 7

Do the patient's signs and symptoms of depression resolve with treatment of comorbid condition(s)?

Take appropriate action if medical diagnoses or conditions are suspected of contributing to depressive symptoms or increasing the likelihood of depression.

Step 8

Clarify the type of depressive disorder.

If the patient's depressed mood (dysphoria) or loss of interest or pleasure (anhedonia) has been present for at least 2 weeks *and* if either dysphoria or anhedonia has contributed to the patient's functional or social impairment or decline and if substance abuse or recent bereavement is *not* present, it is likely that the patient is suffering from a depressive disorder. Before this conclusion is reached, however, a health care practitioner should be consulted to distinguish a depressive disorder from other conditions or combinations of conditions, as discussed above.

Figure 1 in the original guideline (criteria for major depression from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* [DSM-IV-TR]) helps the attending practitioner and interdisciplinary team to discern whether the patient may have a depressive disorder. If at least five of the symptoms listed in Figure 1 are present for at least 2 weeks and if the patient has no history of a prior manic episode, then major depression is likely to be a correct diagnosis.

The scales listed as screening tools in Step 1 above may also be used to diagnose and monitor depression.

Step 9

Does the patient's clinical situation require psychiatric support?

Depression can often be managed readily by primary care practitioners who follow appropriate protocols and guidelines. Effective psychiatric support may not be readily available in the LTC setting. In some cases, however, psychiatric support is helpful (see Table 7 in the original guideline). If possible, consultation with a geriatric psychiatrist or a psychiatrist with expertise in geriatrics should be obtained when there is uncertainty about the diagnosis of depression, when a patient fails to respond to multiple trials of antidepressant therapy or to augmentation therapy, or when a severe or urgent situation exists.

Patients who are suicidal or homicidal, those who are refusing to eat or drink because of depression, or those whose symptoms include delusions, hallucinations, or agitation are candidates for consultation with a geriatric psychiatrist. A specialist consultation may also be helpful for patients who have been unresponsive to an adequate trial of an antidepressant and for those who have multiple, complex coexisting illnesses.

Step 10

Does the patient's depression exhibit serious psychiatric or behavioral complications that may pose a risk to the patient or to others?

Serious grief or bereavement issues and psychiatric disorders other than depression may complicate a depressive episode. Other complicating behavioral comorbidities may include alcohol dependency, substance abuse, and dementia. A consultant with specific expertise in the psychiatric disorders of older adults may be helpful in evaluating the patient for complications of depression.

It is important to determine if the patient is psychotic, severely agitated, aggressive (i.e., potentially dangerous to self or others), neurovegetative, or suicidal. If any of these conditions are present, referral to a geriatric psychiatric unit or consultation with a psychiatrist who has expertise in the care of older adults may be considered, unless the facility's interdisciplinary team has experience in dealing with such patients.

Treatment

Step 11

Implement appropriate and evidence-based nonpharmacologic or complementary treatment for the patient's depression.

General facility-wide approaches that should be available to all patients who can participate include the following:

- Minimize institutional aspects of the environment (e.g., encourage patients to decorate their living spaces with personal items)
- Facilitate interaction with family members and friends important to the patient
- Provide opportunities for patients to engage in spiritual or religious activities if they so desire
- Encourage engagement in socialization and structured, meaningful physical and intellectual activities that are age- and gender-appropriate
- Ensure that care is resident-centered and incorporates the wishes and desires of the individual
- Encourage prompt, positive, genuine relationships between residents and staff as an additional source of social support.

Table: Most Common Nonpharmacologic Interventions for Depression

Intervention	Preferred Techniques
Psychotherapy	• Cognitive-behavioral therapy • Interpersonal therapy • Problem-solving therapy
Psychosocial and other interventions	• Activation (socialization, engagement in productive activity) • Bereavement groups • Exercise • Family counseling • Light therapy • Participation in social events • Psychoeducation

Adapted from Alexopoulos et al. Pharmacotherapy of Depressive Disorders in Older Patients. The Expert Consensus Guideline Series: A PostGraduate Medicine Special Report. 2001. New York: McGraw-Hill.

Step 12

Prescribe appropriate pharmacologic treatment for the patient's depression.

The decision to initiate drug therapy assumes that the interdisciplinary team is already working to establish a therapeutic milieu and that the facility is prepared to manage drug therapy. The practitioner should discuss the rationale for adding pharmacotherapy to the patient's regimen with team members as well as with the patient and his or her family. This discussion should include the goals of drug therapy and potential drug side effects.

The major classes of antidepressants, with representative examples of each class, are listed in Table 11 of the original guideline, and include the following:

- Selective serotonin reuptake inhibitors [SSRIs]
- Tricyclic antidepressants
- Dopamine norepinephrine reuptake inhibitor (bupropion)
- Serotonin norepinephrine reuptake inhibitors [SNRIs]
- Psychostimulants
- Serotonin modulator (trazodone)
- Norepinephrine serotonin modulator (mirtazapine)

Refer to the original guideline for additional discussion of the various drug classes and treatment strategies for different types of depression.

Step 13

Implement appropriate adjunctive treatment for the patient's depression.

Electroconvulsive therapy (ECT) is a safe treatment with no absolute contraindications to its use. ECT should be considered if the patient's condition is rapidly deteriorating or if antidepressant medication is not tolerated or has failed. ECT should be conducted only in an appropriately equipped setting under the supervision of an experienced psychiatrist and anesthesiologist.

Monitoring

Step 14

Monitor the patient's response to treatment for depression.

Document approaches, timetables, and goals of treatment in the interdisciplinary care plan and progress notes. Goals of treatment may include, but need not be limited to, the following:

- Resolution of signs and symptoms of depression
- Improvement of scores on the GDS, CSDD, PHQ-9, or PHQ-9-OV
- Improvement in attendance at and participation in usual activities
- Improvement in sleep patterns

Monitor the patient carefully for side effects specific to each class of medication as well as for interactions between antidepressants and other classes of medications. Establish and document drug dosages, titration schedules, and frequency of testing to check drug levels as appropriate.

Refer to the original guideline for discussion of the following topics:

- Duration of treatment
- Strategies for overcoming treatment resistance
- Depression and medical comorbidities

Step 15

Measure the facility's performance in the management of depression.

Review the management of patients with depression through the facility's quality improvement processes. Indicators that a facility may wish to use to measure the success of its efforts to manage depression are suggested in Table 16 of the original guideline.

Clinical Algorithm(s)

An algorithm is provided in the original guideline document for recognition, assessment, treatment, and monitoring of depression in the long-term care setting.

Scope

Disease/Condition(s)

Depression

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Dietitians

Health Care Providers

Nurses

Occupational Therapists

Pharmacists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Speech-Language Pathologists

Guideline Objective(s)

- To improve the quality of care delivered to patients with depression in long-term care settings
- To guide care decisions and to define roles and responsibilities of appropriate care staff

Target Population

Elderly residents of long-term care facilities at risk for or diagnosed with depression

Interventions and Practices Considered

Diagnosis/Evaluation/Risk Assessment/Screening

1. Patient history
2. Depression screening tests (Geriatric Depression Scale [GDS], Cornell Scale for Depression in Dementia [CSDD], Patient Health Questionnaire 9 [PHQ 9], Staff Assessment of Resident Mood (PHQ-9-OV)
3. Evaluation of patient for signs or symptoms of depression
4. Evaluation of patient for risk factors for depression
5. Monitoring of patient periodically for development of signs and symptoms of depression
6. Medical work-up as indicated for factors that may be contributing to signs and symptoms of possible depression:

- Chemistry profile (electrolytes, blood urea nitrogen, creatinine, glucose)
- Complete blood count
- Folate level
- Vitamin B 12 level
- Thyroid function (T3, T4, thyroid stimulating hormone [TSH])
- Other possible tests (electrocardiogram, serum calcium level, serum level of digoxin or theophylline if taking either medication, urinalysis, cognitive screen, albumin level, urinalysis, polysomnography)

7. Evaluation of patient for medications that might cause or contribute to depression
8. Adjusting or stopping problematic medications or indicating clearly why this is not feasible
9. Evaluation of patient for comorbid conditions with an increased risk of depression or that may cause depressive symptoms
10. Evaluation of patient's response to treatment of comorbid condition(s)
11. Clarifying the diagnosis using *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition, Text Revision* (DSM-IV-TR) definitions and diagnostic tools (same as screening tools previously listed above)

Management/Treatment

1. Consultative support with psychiatric specialist as indicated
2. Evaluation of potential for complications that may pose a risk to the patient or to others
3. Individualized treatment for the patient's depression
    - Psychotherapy (cognitive-behavioral therapy, interpersonal therapy, problem-solving therapy, supportive therapy)
    - Psychosocial and other interventions (bereavement groups, family counseling, participation in social events, psychoeducation, exercise, light therapy, activation [socialization, engagement in productive activity])
    - Medications (short-acting selective serotonin reuptake inhibitors [SSRIs]; tricyclic antidepressants; dopamine norepinephrine reuptake inhibitors [bupropion]; serotonin norepinephrine reuptake inhibitors [SNRIs]; psychostimulants; serotonin modulator [trazodone]; norepinephrine serotonin modulator [mirtazapine])
    - Electroconvulsive therapy (ECT)
    - Combinations of above therapies
4. Monitoring of patient's response to treatment

Major Outcomes Considered

- Treatment response, recovery, remission, relapse, and recurrence
- Safety of medications used to treat depression

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Medline, PubMed, and geriatric-specific journals such as the Journal of the American Medical Directors Association (JAMDA), Annals of Long Term Care, and Journal of the American Geriatrics Society (JAGS) were searched from May 2009 through February 2011. Studies were included if they met the following criteria:

- Studies that are valid, consistent, applicable and clinically relevant
- Studies where the recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence)

Searches were specific to the guideline topic under consideration.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Original guidelines are developed by interdisciplinary workgroups, using a process that combines evidence and consensus-based approaches. Workgroups include practitioners and others involved in patient care in long-term care facilities. Beginning with pertinent literature searches for articles and information related to the guideline subject, and a draft outline/framework, each group works to make a concise, usable guideline that is tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations are applied research of older adults and geriatric medicine. Some recommendations are based on the expert consensus opinion of practitioners and geriatric experts in the field.

Guideline revisions are recommended under the direction of the Clinical Practice Guideline (CPG) Steering Committee. The Steering Committee reviews any American Medical Directors Association (AMDA) guidelines that are three years old prior to an annual Steering Committee meeting to determine if the CPG is current. (A thorough literature review is done for each CPG as well to ascertain if the data within is still current.) The AMDA Clinical Practice Committee Chair selects the guidelines to be revised/created based on 1) the Steering Committee recommendations, 2) data collected, and 3) an assessment of the difficulty of development and relevance to the AMDA membership. The Board of Directors has final approval. The guideline revision process is similar to the original guideline process, except the workgroup starts with the original guideline (or last revision) as a basis to begin with.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

All American Medical Directors Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

AMDA's guidelines are supported by the following associations/organizations, who are members of its Clinical Practice Guideline Steering Committee. These associations/organizations all have representatives who participate in the external review phase and officially sign off on the guideline before publication: American Association of Homes and Services for the Aging (Now LeadingAge); American College of Health Care Administrators; American Geriatrics Society; American Health Care Association; American Society of Consultant Pharmacists; Gerontological Advanced Practice Nurses Association; Direct Care Alliance; National Association of Directors of Nursing Administration in Long-Term Care; National Association of Health Care Assistants.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary work group using a process that combined evidence and consensus-based approaches. Because scientific research in the long-term care population is limited, many recommendations are applied research of older adults and geriatric medicine. Some recommendations are based on the expert consensus opinion of practitioners and geriatric experts in the field.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Improved recognition, assessment, treatment, and monitoring of depression in the long-term care facility
- Improved screening of patients with the use of an appropriate screening tool for depression
- Improved diagnosis of a depressive disorder in patients experiencing symptoms of depression for at least 2 weeks
- More appropriate use of depression rating scales to monitor depression
- Improved implementation of facility-wide nonpharmacologic treatment approaches to depression
- More appropriate pharmacologic treatment of depression and elimination of inappropriate pharmacotherapy

Potential Harms

Adverse Effects of Antidepressant Agents

- Selective serotonin reuptake inhibitors (SSRIs): insomnia, agitation, somnolence, decreased appetite, initial weight loss. Specific agents have potential for interaction with components of cytochrome system.
- Tricyclic antidepressants: dry mouth, blurred vision, constipation, urinary retention, inhibition of sweating, cognitive dysfunction, arrhythmia, orthostatic hypotension, delirium
- Bupropion: seizures (in at-risk patients), hypertension, dry mouth
- Serotonin norepinephrine reuptake inhibitors (SNRIs): same as short-acting SSRIs; risk of blood pressure elevation at higher doses (>150–225 mg/day), dry mouth

- Psychostimulants: anxiety, cardiac arrhythmia, insomnia, anorexia, weight loss, elevated blood pressure
- Serotonin modulator (trazodone): sedation, postural hypotension (at high doses), priapism (rare)
- Norepinephrine serotonin modulator (mirtazapine): increased appetite, weight gain, sedation, somnolence, interaction with certain cytochrome pathways, increased cholesterol

Refer to Table 11 in the original guideline for additional cautions.

Because most antidepressants are susceptible to drug interactions, it may be necessary to adjust the doses of a patient's other medications in order to achieve therapeutic effects from antidepressants without intolerable side effects. Because the tricyclic antidepressants have narrow therapeutic indices, any interference with their metabolism may lead to serious adverse reactions, which are more common as well as more likely to be life-threatening in older adults.

Contraindications

Contraindications

- Tertiary amine tricyclics (e.g., amitriptyline, doxepin, imipramine) should not be used to treat depression in elderly LTC patients because of the unacceptable side effects associated with their strong binding to norepinephrine and serotonin.
- Patients with seizure disorders should not receive bupropion.
- Psychostimulants should not be used in patients with known serious structural cardiac abnormalities, cardiomyopathy, or serious heart rhythm abnormalities because of the increased risk of sudden death.

Qualifying Statements

Qualifying Statements

- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association (AMDA) and the American Health Care Association, their heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of AMDA's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinician's ability to practice.
- Long-term care facilities care for a variety of individuals, including younger patients with chronic diseases and disabilities, short-stay patients needing postacute care, and very old and frail individuals suffering from multiple comorbidities. When a workup or treatment is suggested, it is crucial to consider if such a step is appropriate for a specific individual. A workup may not be indicated if the patient has a terminal or end-stage condition, if it would not change the management course, if the burden of the workup is greater than the potential benefit, or if the patient or his or her proxy would refuse treatment. It is important to carefully document in the patient's medical record the reasons for decisions not to treat or perform a workup or for choosing one treatment approach over another.

Implementation of the Guideline

Description of Implementation Strategy

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. Recognition
    - Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and

feasibility of implementing the CPG.

II. Assessment
    - Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes.

III. Implementation
    - Identify and document how each step of the CPG will be carried out and develop an implementation timetable.
    - Identify individual responsible for each step of the CPG.
    - Identify support systems that impact the direct care.
    - Educate and train appropriate individuals in specific CPG implementation and then implement the CPG.

IV. Monitoring
    - Evaluate performance based on relevant indicators and identify areas for improvement.
    - Evaluate the predefined performance measures and obtain and provide feedback.

Table 16 in the original guideline document suggests sample performance measurement indicators (process indicators and outcome indicators).

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Clinical Algorithm

Tool Kits

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 (revised 2011)

Guideline Developer(s)

American Medical Directors Association - Professional Association

Guideline Developer Comment

Organization participants included:

- American Association of Homes and Services for the Aging
- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- Direct Care Alliance
- Gerontological Advanced Practice Nurses Association
- National Association of Directors of Nursing Administration in Long-Term Care
- The American Medical Directors Association (AMDA) Foundation

Source(s) of Funding

American Medical Directors Association

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Financial Disclosures/Conflicts of Interest

All contributors must submit an Accreditation Council for Continuing Medical Education (ACCME) approved disclosure form prior to being accepted as a volunteer member of the guideline workgroup. This disclosure form is reviewed by the chair of the American Medical Directors Association (AMDA) Clinical Practice Committee. If any conflicts are perceived, that person is not accepted to be part of the workgroup.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Depression. Columbia (MD): American Medical Directors Association (AMDA); 2003. 36 p.

Guideline Availability

Electronic copies: Not available at this time.

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

Availability of Companion Documents

The following is available:

- Depression tool kit. Available to order from the American Medical Directors Association (AMDA) Web site.

In addition, Table 16 in the original guideline document provides sample performance measurement indicators. The appendices to the guideline provide various assessment questionnaires and checklists.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on July 6, 2004. The information was verified by the guideline developer on August 4, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This NGC summary was updated by ECRI Institute on October 31, 2011. The updated information was verified by the guideline developer on November 29, 2011. This summary was updated by ECRI Institute on April 16, 2012 following the updated U.S. Food and Drug

Administration advisory on Celexa (citalopram hydrobromide).

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